



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL FORT WORTH
750 12TH AVE
FORT WORTH TX 76104-2517

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4561-01

MFDR Date Received

August 1, 2011

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2011	Outpatient Hospital Services	\$4,256.22	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bills for health care provided to the injured worker to the injured worker's employer. No documentation was found to support that the medical bills were ever presented to the workers' compensation insurance carrier for payment. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

Conclusion

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties, and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	Grayson Richardson	October 5, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.